PEHCCP Research

- Prompted by:
  - Questions raised by potential administrators
  - Conversations with other states' staff
  - Concerns of IHPS staff
- Includes recent reports from:
  - U.S. General Accounting Office
  - Economic & Social Research Institute
  - Wake Forest study sponsored by Robert Wood Johnson Foundation

Expectations of pooling

- Pooled risk for more stable premiums
- Leveraged negotiating power
- Administrative efficiencies
- Head-to-head competition among multiple insurers with standard benefit designs
- Greater doctor-patient continuity

Limited success to date

- "Pooled" risk unworkable
- Small market share, so little leverage
- Administrative savings elusive
- Health plan offerings
  - Multiple insurers in states with significant rating restrictions
  - Otherwise, plan designs with single carrier
- More PPO/POS options available outside

"Mirror your market"

Learned from others:

To protect insurers and the pool, rating and participation rules inside the pool should mimic, as much as possible, rules in the outside market.

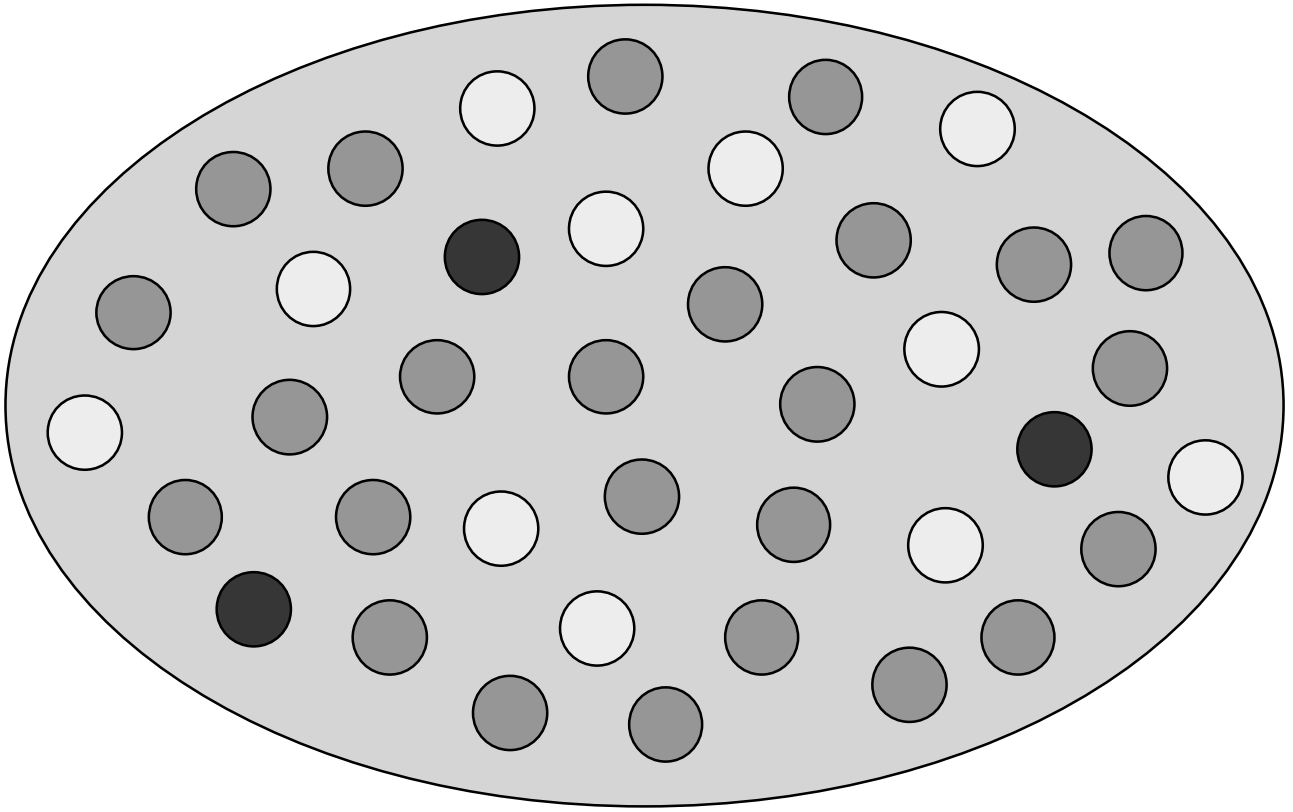
"If the pools are open to all employers while the rest of the market is not, then they may become dumping grounds for high-risk employer groups, leading to spirals of adverse selection."

—Long & Marquis

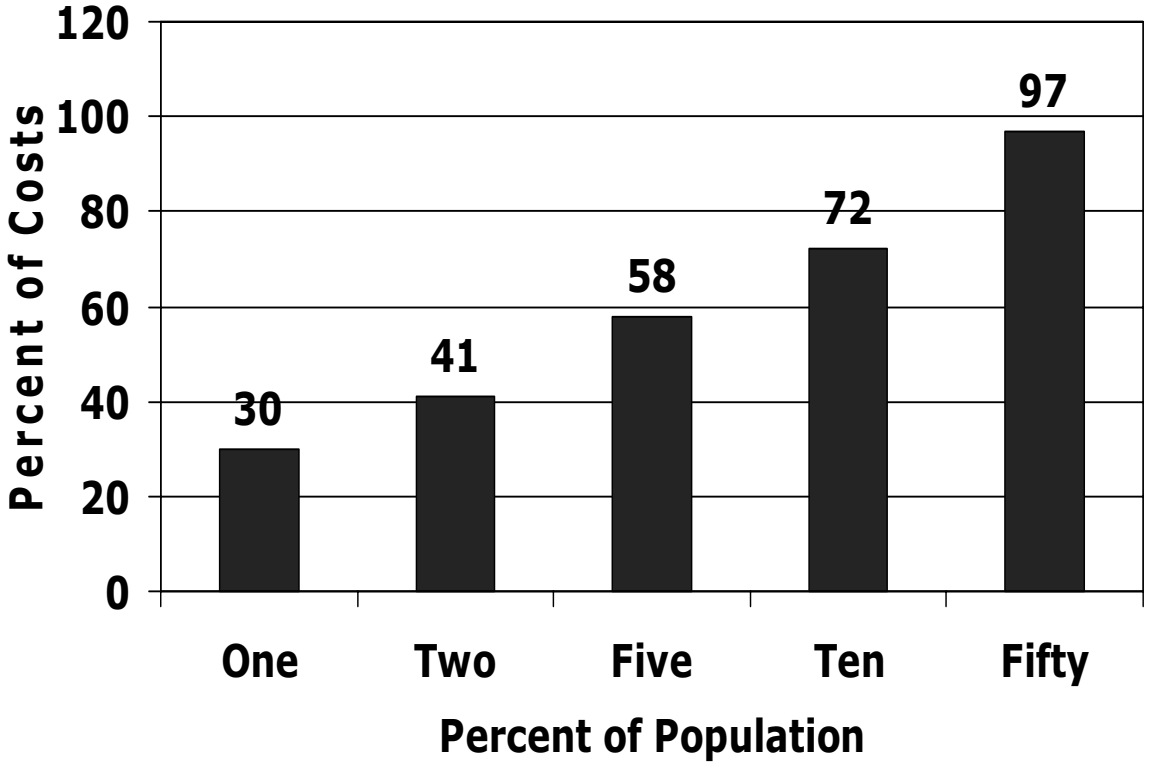
Background/history

- Early forms of health insurance
  - Pure community rating: just single/family
- Introduction of commercial carriers
  - Demographic rating based on age/sex, modeled on life insurance
- Introduction of other rating factors
  - Industry (30-40 years ago)
  - Claims experience (~20 years ago)

Complete risk spreading



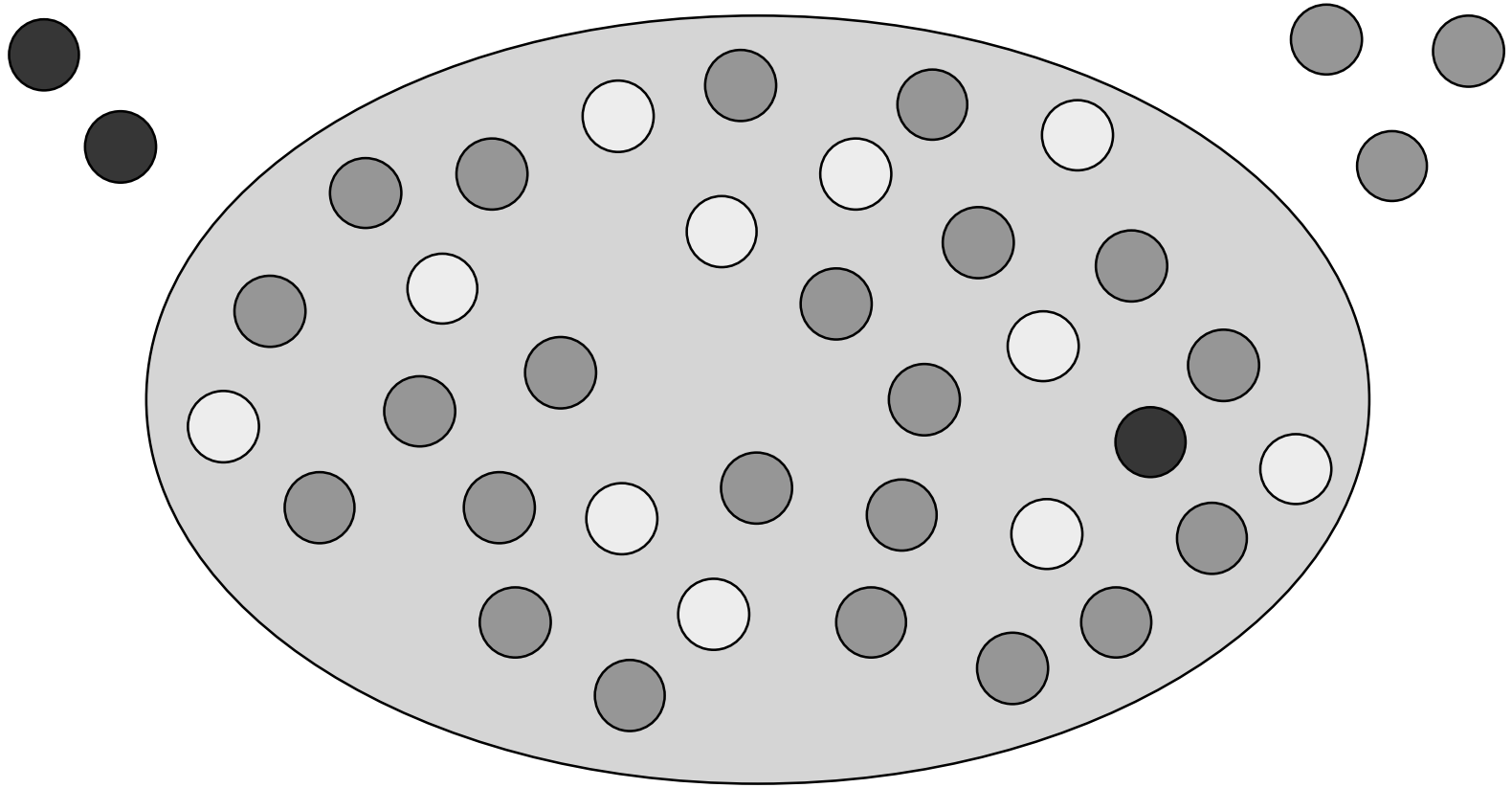
Percent of Total Health Costs Accounted for by Percent of U.S. Population (under 65)



"By far the easiest way for insurers to keep premiums down, attract new business, and make profits is to avoid insuring high-risk individuals and high-risk groups."

—Wick & Meyer

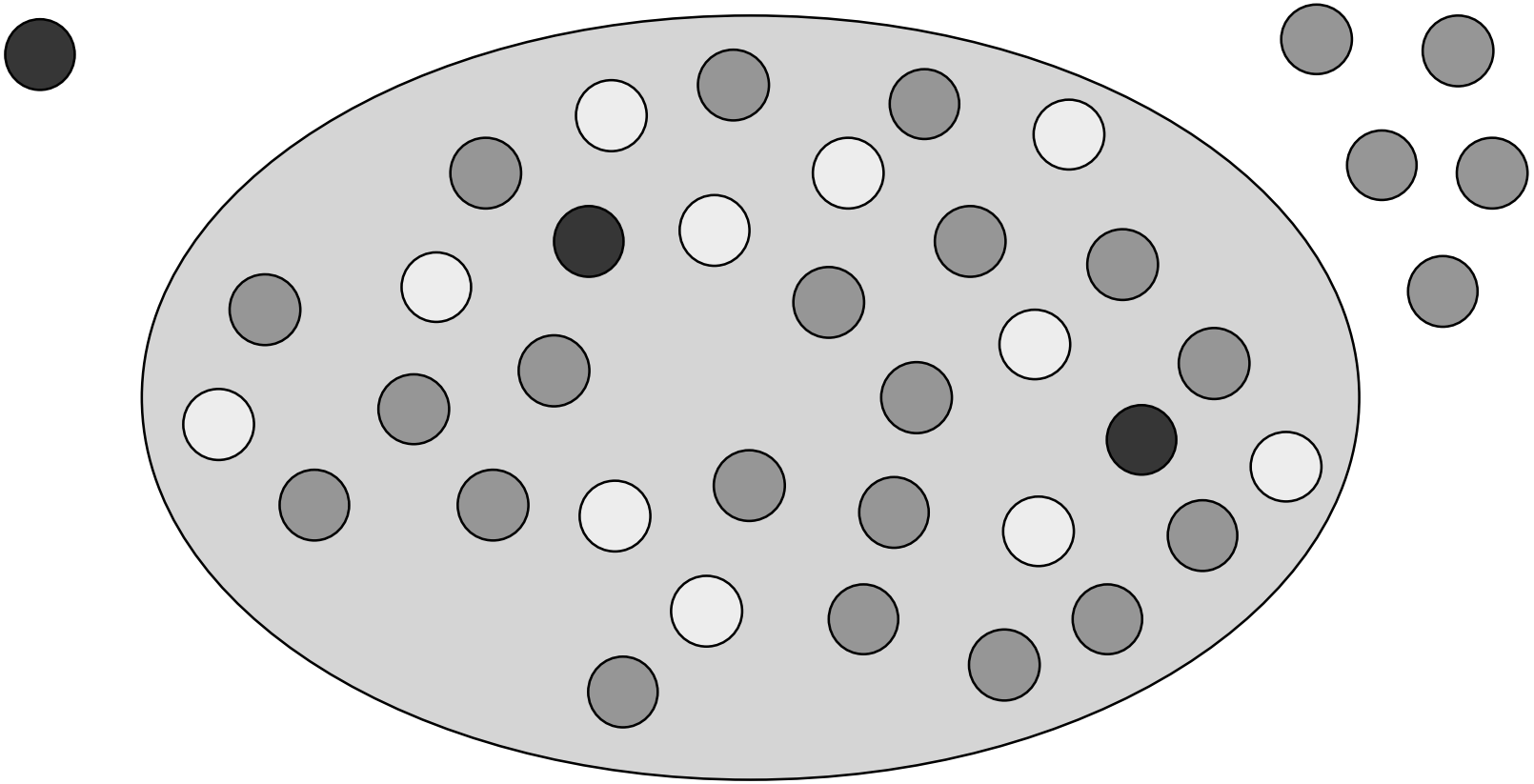
No rating restrictions



Continuum of rating limits

- Rate bands
  - Differential not to exceed ____%
- Adjusted community rating by class
  - "Class" may be claims experience, industry
- "Modified" community rating
  - Health status/claims experience prohibited
  - Age, sex, other "objective" factors allowed
- "Pure" community rating
  - Only single/family, geography, product

Rate bands



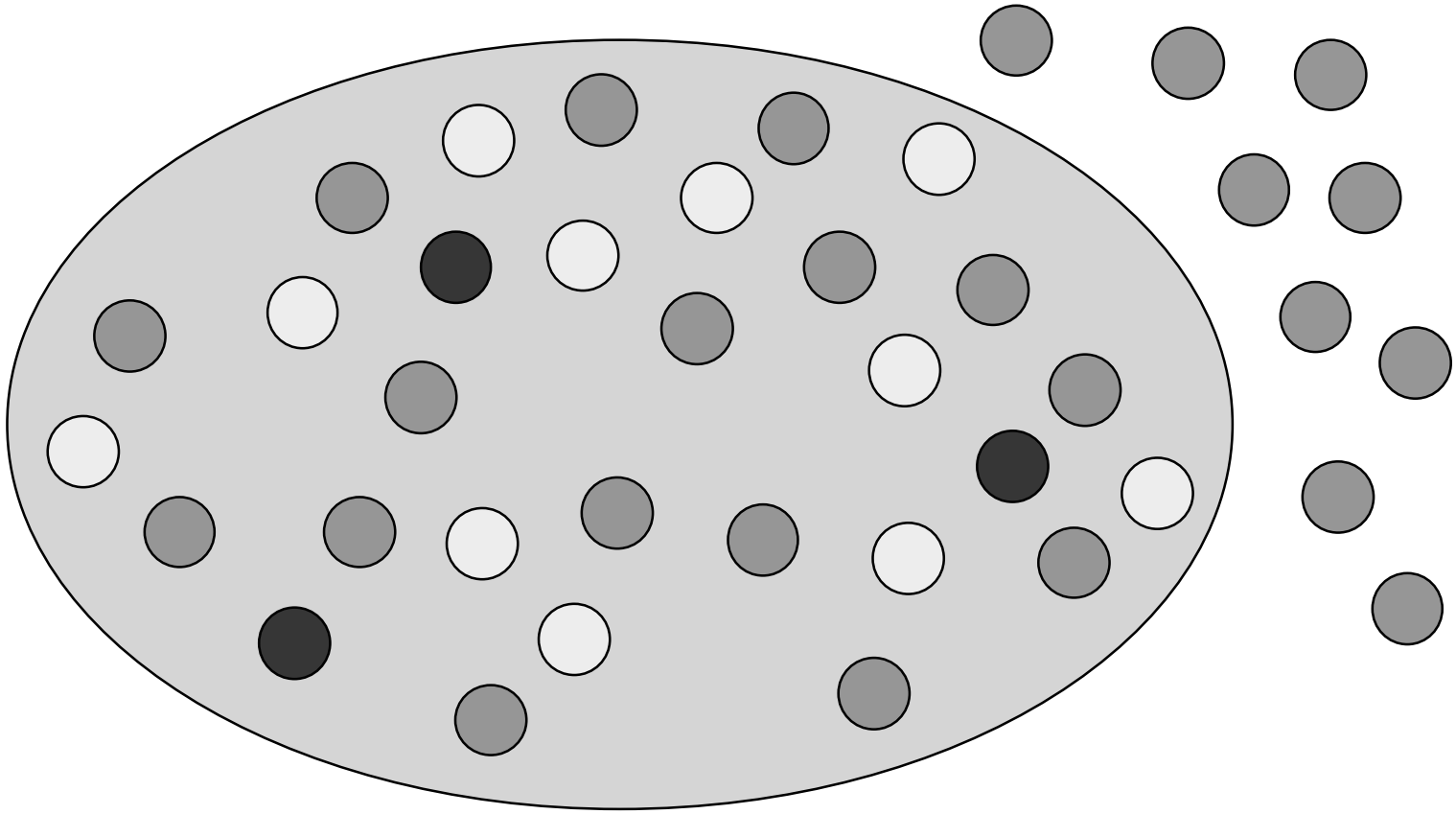
Limiting use of health status

- More stable rates
- Healthier pay more, sicker pay less
- Stronger incentives for competition based on cost and quality
- Exodus of less advanced indemnity carriers; growth in managed care market share

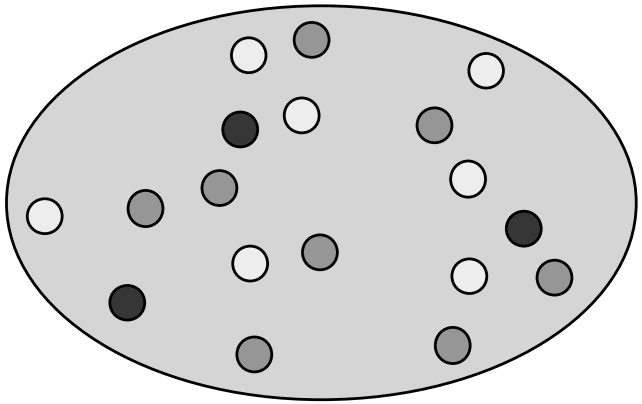
Limiting use of other factors

- Sex
  - Predominantly male groups pay more; predominantly female groups pay less
  - Potential increases in uninsured
- Age
  - Young pay more; old pay less
  - On average, financially regressive
  - Potential increases in uninsured
  - Carriers with less market share likely to exit

“Pure” community rating



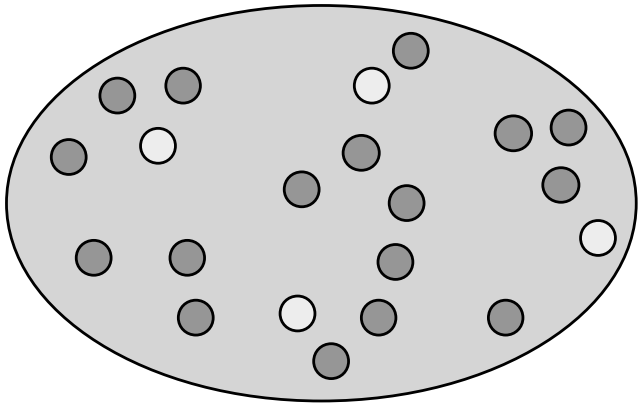
Potential adverse selection



Pool Rates

S: $250

F: $750



Market Rates

S: $100

F: $300

S: $250

F: $750

S: $500

F: $1500

Example: Texas

- State-established non-profit corp.
- Coverage first available in 1994
- Community rating inside, not outside
  - Rates up to 30% different than market
  - "Death spiral"
  - Changed in 1997, but insurers out
- Peak enrollment 13,000 lives (0.3%)
- Program folded July 1999

Example: California

- State-established pool, now private
- Coverage first available in 1993
- Community rating inside, 10% rate bands outside
- Retrospective risk adjustment
- Pool rates 7-8% higher, on average
- Accounts for ~2% of small group market in the state (~145,000 lives)

Example: Colorado

- Private employer coalition
- Coverage first available in 1995
- Community rating statewide
- Four of five major health plans
- Pool rates close to market
- Accounts for ~2% of small group market in the state (~18,000 lives)
- Average group size 4.4 (groups <50)

Example: Connecticut

- Private business association
- Coverage first available in 1995
- Community rating statewide
- Self-administered
- All four insurers offer both HMO and POS to prevent adverse selection
- Accounts for ~8% of small group market in the state (~55,000 lives)

Example: Kansas

- Private employer purchasing group
- Coverage first available in 1999
- Rate bands inside and outside
- Single carrier with multiple plan designs (HMO, POS)
  - No need for administrator or centralized underwriting
- May become conduit for state subsidies for low-income employees

Possible, but no example yet

- Rate bands inside and outside
- Multiple carriers with multiple plan designs
- Common rating methodology
- Centralized underwriting, renewal processes
- Administrator for enrollment/billing

Core capabilities

- The administrator must be able to:
  - Secure contracts with health plans
  - Collect and distribute eligibility data
  - Collect and distribute premium
  - Administer commission payment system
  - Develop and implement a marketing plan
  - Respond to employer/enrollee questions
  - Conduct employer/enrollee survey(s)
  - Generate management reports

Additional program needs

- Program **without** community rating also requires:
  - Standard methodology for determining rates for each group, agreed upon by all participating health plans
  - Individual(s) to conduct underwriting
  - Health plan data on which to base renewal rates for each group
  - More complex marketing materials

Administrators' questions

- Program rules and expectations
- Wisconsin rating regulations
- Roles and responsibilities
- Anticipated timeline
- Health plan interest
- Employer interest/potential market
- Availability of start-up funds

Typical health plan objections

- Potential for adverse selection
- Competition with existing products (especially well-established plans)
- Dilutes agent relationships
- Additional state filings
- Administrative overhead not reduced